State of Montana
Office of the Legislative Auditor

Performance Audit

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Medicaid Eligibility Determination Process

This report contains recommendations for changes in the operation and management of the eligibility determination process of the Medicaid program. The recommendations include:

- SRS taking a more active role in managing the eligibility determination program.
- Redesigning and consolidating the forms used by eligibility technicians.
- SRS helping counties establish practices that will allow assistance programs in the counties to operate more efficiently.

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The Legislative Audit Committee
of the Montana Legislature:

This is our performance audit of the Medicaid Eligibility Determination Process of the Department of Social and Rehabilitation Services.

This report contains conclusions and recommendations concerning department procedures in relation to the eligibility determination process. Department responses are contained at the end of the report.

We wish to express our appreciation to the staff of the department for their cooperation and assistance.

Respectfully submitted,

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SUMMARY OF RECOMMENDATIONS

The following is a listing of recommendations of our performance audit of the Medicaid Eligibility Determination Process of the Medicaid Program. SRS's response to each recommendation follows the recommendation. SRS concurred with each recommendation. See indicated page numbers for additional information related to each area. See Chapter II for an overview of the Montana Medicaid program and eligibility requirements.

CHAPTER III

EFFICIENCY OF ELIGIBILITY DETERMINATION (page 26)

We found the general process used by eligibility technicians in their determinations of eligibility is consistent; however, the actual office procedures may differ between counties. SRS has provided minimal guidance to counties concerning how to operate efficiently, either in the processes used or information distributed.

Recommendation #1 (page 27)

WE RECOMMEND SRS TAKE A MORE ACTIVE ROLE IN MANAGING THE ELIGIBILITY DETERMINATION PROGRAM.

Agency Response: Concur (page 62)

CHAPTER IV

ELIGIBILITY DETERMINATION PROCESS

ELIGIBILITY PROCEDURES

Verification of Resources (page 30)

Information provided us during visits to counties indicates eligibility technicians rely almost entirely on what the clients tell them during the initial determination process. The problem can be addressed by increasing the information available to eligibility technicians.

Recommendation #2 (page 32)

WE RECOMMEND THE DEPARTMENT CONTINUE ITS EFFORTS TO INCREASE THE INFORMATION AVAILABLE TO ELIGIBILITY TECHNICIANS TO VERIFY INFORMATION PROVIDED BY CLIENTS.

Agency Response: Concur (page 62)

Consolidation of Forms (page 32)

Eligibility technicians normally handle over 150 forms in the course of their work. Some of the forms and informational sheets contain or require virtually the same information.

Recommendation #3 (page 34)

WE RECOMMEND THE DEPARTMENT REDESIGN AND CONSOLIDATE THE FORMS USED BY ELIGIBILITY TECHNICIANS.

Agency Response: Concur (page 62)

Eligibility Intake Checklist (page 35)

During our review of client files we found the eligibility intake checklist is not consistently used. Having the client sign the form provides evidence the client was informed of his/her rights and responsibilities.

Recommendation #4 (page 36)

WE RECOMMEND THE DEPARTMENT:

A. EXPLAIN THE NEED OF THE ELIGIBILITY INTAKE CHECKLIST FORM TO THE ELIGIBILITY TECHNICIANS.

B. REVIEW A SAMPLE OF CASES TO ENSURE ELIGIBILITY TECHNICIANS ARE OBTAINING THE CLIENT'S SIGNATURE ON THE FORM.

Agency Response: Concur (page 63)

SRS' ADMINISTRATIVE ROLE IN THE ELIGIBILITY PROCESS

Number of Mistakes on Turnaround Documents (page 36)

In reviewing why the number of mistakes on turnaround documents decreased overall, we noticed fluctuations in the number of mistakes occurring in the months between April and August. It became evident SRS personnel do not routinely monitor this information for management purposes since no one was aware the number of mistakes had gone up in some months or why.

Demographical Information (page 37)

We asked SRS personnel for information concerning the ages and distribution of people eligible for AFDC and Medicaid. Department personnel informed us they do not have such information readily available.

Conclusion on Use of Information (page 37)

SRS has information available concerning numbers of mistakes that are occurring that could be beneficial in expediting the eligibility determination process. SRS also gathers information pertaining to the composition of eligible recipients which it does not utilize.

Recommendation #5 (page 38)

WE RECOMMEND THE DEPARTMENT USE AVAILABLE INFORMATION TO:

A. IDENTIFY PROBLEMS ELIGIBILITY TECHNICIANS COULD BE HAVING IN COMPETING FORMS.

B. MONITOR THE ELIGIBLE POPULATION.

Agency Response: Concur (page 63)

CHAPTER V

DEVELOPMENT OF POLICIES

POLICY DEVELOPMENT PROCESS

Receipt of Policies (page 42)

While in the counties we found not all eligibility technicians had up-to-date Medicaid and AFDC policies. Eligibility technicians in five of thirteen counties were missing one or more of the policies.

RECOMMENDATION #6 (page 43)

WE RECOMMEND THE DEPARTMENT TAKE STEPS TO ASSURE:

A. EVERYONE IS RECEIVING POLICIES.

B. POLICIES ARE BEING PLACED IN THE MANUALS.

Agency Response: Concur (page 64)

BULLETINS (page 43)

In our visits to the counties we found the Eligibility Policy Bureau is not following its policy of updating bulletins within four months of the date they are issued. This situation has created some

confusion in the field because eligibility technicians are not sure whether they are to follow bulletins after the four months has elapsed or if they are to revert to the old policy.

Recommendation #7 (page 44)

WE RECOMMEND THE DEPARTMENT REVIEW ITS POLICY CONCERNING UPDATING BULLETINS TO DETERMINE WHETHER THE CURRENT POLICY IS NEEDED.

Agency Response: Concur (page 64)

CHAPTER VI

APPEALS PROCESS

HEARINGS FINDINGS

Timeliness of Findings (page 47)

Three hundred twelve requests for fair hearings were received by SRS between April 9, 1984 and October 5, 1984. Seventy-nine of the findings were not completed in the 90 day time limit established by federal regulations. Documentation indicating why cases are not completed in a timely manner should be maintained in all the cases.

Recommendation #8 (page 49)

WE RECOMMEND THE DEPARTMENT:

A. STRESS THE NEED FOR TIMELY ADMINISTRATIVE REVIEWS IN THE COUNTIES.

B. DOCUMENT REASONS FOR NOT MEETING THE 90-DAY TIME LIMIT.

Agency Response: Concur (page 64)

CHAPTER VII

MONTANA INCOME MAINTENANCE SYSTEM (MIMS)

MIMS INFORMATION

Matches (page 51)

Eligibility technicians are provided information that "matches" clients on MIMS with information on other computer systems.

These computer matches are performed monthly and/or quarterly. Eligibility technicians indicated they would like some matches done more often than quarterly.

Recommendation #9 (page 52)

WE RECOMMEND THE DEPARTMENT MATCH THE INFORMATION ON MIMS TO THE DEPARTMENT OF LABOR TAPES MONTHLY SO NEW CLIENTS WILL BE LISTED ON THE MATCHES.

Agency Response: Concur (page 64)

MIMS Reports (page 52)

Counties are provided with at least 27 computer reports. In August 1984 SRS obtained comments from ET supervisors concerning what changes to the reports the county staff would like. As of November none of the requested changes had been made.

Recommendation #10 (page 53)

WE RECOMMEND THE DEPARTMENT ASSESS THE USE AND NEED OF THE COMPUTER REPORTS SENT TO COUNTIES AND MODIFY OR DELETE THOSE NOT PRESENTLY UNDERSTOOD OR USED BY COUNTY STAFF.

Agency Response: Concur (page 65)

CONTROLS OVER INFORMATION

Issuance of Medicaid Cards (page 55)

In our visits in the counties we found people listed with two identification numbers and issued two Medicaid cards.

Recommendation #11 (page 56)

WE RECOMMEND ELIGIBILITY TECHNICIANS:

A. PERIODICALLY REVIEW THE MEDICAID IDENTIFICATION CARD REGISTER TO ENSURE PEOPLE ARE ONLY RECEIVING ONE CARD.
B. HAVE ANY INCORRECT NUMBERS DELETED SO PEOPLE DO NOT RECEIVE TWO CARDS UNDER TWO NUMBERS.

Agency Response: Concur (page 65)

Third-Party Liability Information on TADs (page 56)

We found eligibility technicians are not completing turnaround documents properly so third-party liability information is identified with a particular person.

Recommendation #12 (page 57)

WE RECOMMEND THE DEPARTMENT:

A. INSTRUCT ELIGIBILITY TECHNICIANS TO PROPERLY COMPLETE THIRD-PARTY LIABILITY INFORMATION.

B. DEVELOP AN EDIT IN MIMS TO ASSURE THIRD-PARTY LIABILITY INFORMATION IS PROPERLY RECORDED ON THE TAD.

Agency Response: Concur (page 65)

CHAPTER VIII

COUNTY WELFARE OFFICE ORGANIZATION

INTAKE PROCESS (page 58)

While conducting our audit we noticed each county welfare office had different office procedures for accomplishing similar tasks in the eligibility process. We found the method of distributing applications differs in the counties visited. We also found the process of seeing clients differs. The third process that differed between counties concerns the type of cases the ETs handle.

FORM LETTERS (page 59)

We found eligibility technicians must communicate, through a letter, to their clients quite frequently. We found instances where letters were sent every month informing clients of changes. Some counties type a new letter each time the client needs to be informed.

SUMMARY (page 60)

SRS should help counties become more efficient, thus creating more available time for eligibility technicians. State statutes direct the department to "... provide services in respect to organization and supervise county Department of Public Welfare and county Boards of Public Welfare in the administration of public assistance functions and for efficiency and economy." (53-2-201,1(e), MCA).

Recommendation #13 (page 60)

WE RECOMMEND THE DEPARTMENT HELP COUNTIES ESTABLISH PRACTICES THAT WILL ALLOW ASSISTANCE PROGRAMS IN THE COUNTIES TO OPERATE MORE EFFICIENTLY.

Agency Response: Concur (page 66)

CHAPTER I

INTRODUCTION

A performance audit of the eligibility determination process of the Medicaid program, administered by the Department of Social and Rehabilitation Services (SRS), was requested by the Legislative Audit Committee. The audit request was approved after a preliminary survey of the Medicaid program was presented to the Legislative Audit Committee in June 1984. This report summarizes the results of our performance audit.

OBJECTIVES OF AUDIT

The four main objectives of this audit were:

1. To determine the duties of eligibility technicians and how the performance of these duties affects determination of initial and continuing eligibility of clients.

2. To determine the process of Medicaid policy development.

3. To determine the volume, accuracy, and timeliness of appealed decisions regarding determinations.

4. To determine the effectiveness of current data processing methods in assisting with eligibility determinations.

In addition, this report is intended to present independent information on how Medicaid eligibility is determined in Montana. We have included our conclusions and recommendations in specific areas of the eligibility determination process.

SCOPE OF AUDIT

The audit focused on the eligibility determination process of the Medicaid program. This is one of five audits of the Medicaid program which was identified as feasible by our June 1984 survey of the program. We have already presented our audit pertaining to Medicaid administrative support functions to the Legislative Audit Committee. The three remaining areas that will be covered in later performance audits are:

1. Administration of the Fee-Based Provider Program.
2. Administration of the Cost-Based Provider Program.
3. Quality Control.

The audit was conducted in accordance with generally accepted governmental performance auditing standards. The audit did not include a review of the financial status of the department. A financial-compliance audit of SRS is done by the Office of the Legislative Auditor biennially.

As part of our audit we visited thirteen county welfare offices to evaluate the eligibility process. While in the counties we reviewed client case files, observed procedures for specific functions, and interviewed department field staff.

We reviewed department files in Helena pertaining to appeal decisions, policy creation, and department audits of a selected sample of client case files. We also interviewed department personnel.

During the audit we asked officials at SRS for written responses to selected audit points. These areas related to potential report issues and recommendations, and informed SRS management of issues during the audit, rather than after audit completion.

We also compared information on the Montana Income Maintenance System (described in Chapter VII) and the Medicaid Management Information System. A concern had been identified in our audit of Medicaid administrative support functions concerning discrepancies between the two computer systems. The problems noted during our first audit appear to have been addressed.

COMPLIANCE

As part of our audit we reviewed compliance with laws, administrative rules, and policies relating to the Medicaid eligibility determination process. Specific instances of noncompliance with laws, rules, or policies that were found in our examination are discussed in related report sections. For items we did not test, nothing came to our attention that would indicate significant instances of noncompliance.

CHAPTER II

BACKGROUND

Medicaid is an economic assistance program designed to provide medical services to the needy. The program has two major goals: 1) to ensure health care is available to those who otherwise could not afford it; and 2) to improve people's health and thus reduce their dependence on other forms of public aid.

This chapter will provide: 1) a brief history of the Medicaid program; 2) an overview of the eligibility requirements that must be met to receive Medicaid benefits; 3) the number and distribution of eligible clients; and 4) an overview of the roles of the Department of Social and Rehabilitation Services (SRS) and the counties in the determination process.

HISTORY OF MEDICAID

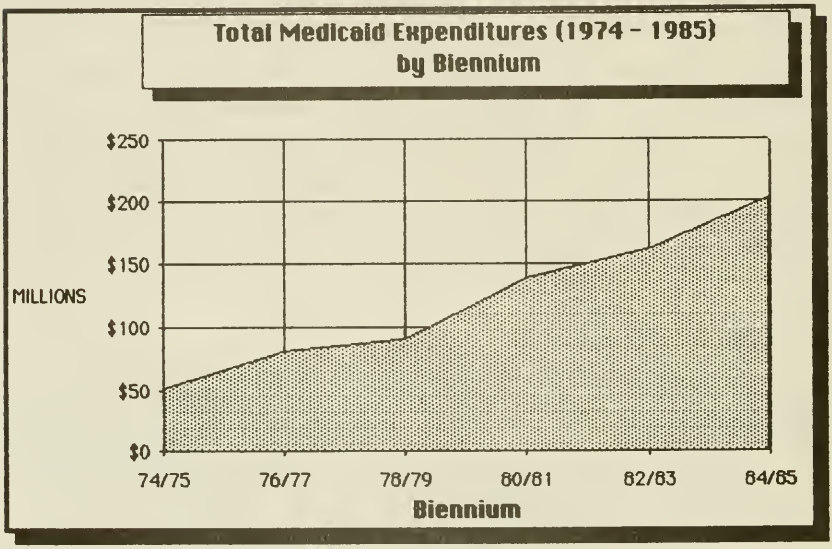
The Montana Medicaid program was established in 1967 as a federal-state partnership with the federal government providing financial support and basic program guidelines. SRS administers the program but must provide specific care requirements set forth by the federal government to receive matching funds.

With its inception in Montana, only basic services were offered by Medicaid: hospitalization, physicians, skilled nursing home care, prescription drugs, and dental. In 1968, optional services such as intermediate care facilities, medical equipment, and treatment by optometrists and podiatrists were included. In 1974 the Medically Needy Program was implemented.

Major changes have been made in the Medicaid program since its inception. The most recent change in federal guidelines is DEFRA - The Deficit Reduction Act of 1984. Beginning October 1, 1984, DEFRA mandated that all states increase the allowable income limit for people applying for Aid to Families with Dependent Children (AFDC). This act will have the effect of increasing the number of persons eligible to receive Medicaid benefits.

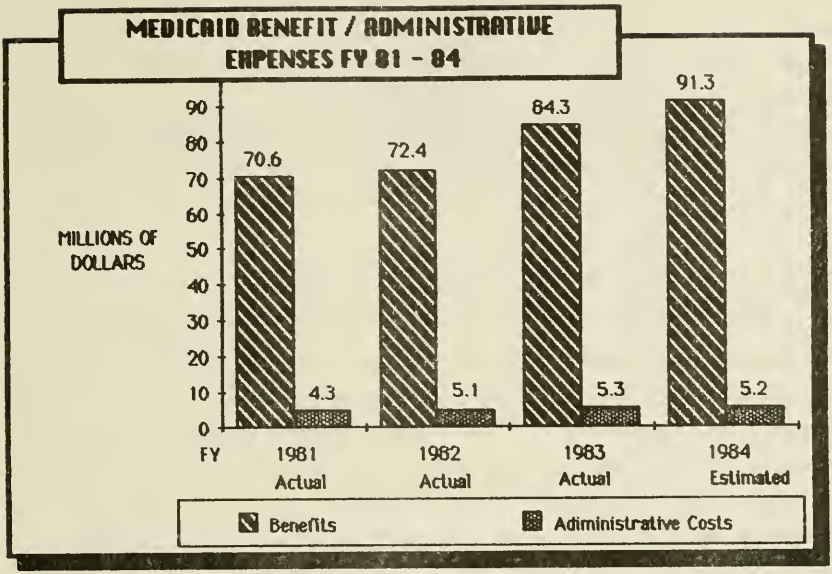
MEDICAID EXPENDITURES

Medicaid expenditures have grown dramatically. Nationally, expenditures increased almost 200 percent from 1974 to 1984 while in Montana an increase of 300 percent occurred over the same period. Illustrations 1 and 2 show the trend in Medicaid expenditures for Montana (includes both state and federal dollars).



Source: SRS Statistical Reports and Date of Service Reports

Illustration 1



Source: SRS Statistical Reports and SRS Fiscal Bureau

Illustration 2

Medicaid expenditures are jointly funded by federal and state governments. The rate of federal financial participation is calculated from a formula using the state's per capita income and the national average per capita income. Federal participation for benefits expenditures can vary from a minimum of 50 percent to a maximum of 83 percent. The federal participation rate for Montana for fiscal year 1983-84 was approximately 62 percent.

WHO IS ELIGIBLE

Medicaid eligibility is determined largely by specific criteria established by the federal government. All recipients of cash assistance under Title IV, Aid to Families with Dependent Children (AFDC), or Title XVI, Supplemental Security Income (SSI), of the Social Security Act are eligible for Medicaid benefits. Federal law requires that all states participating in Medicaid provide services to these "Categorically Needy" people. Medicaid coverage can also

be extended to the "Medically Needy." "Medically Needy" are persons who meet all but the income criteria for "Categorically Needy," yet, due to medical care expenses, their income is not sufficient to meet the costs of their health care.

The Montana Medicaid program offers coverage to both categorically and medically needy. A description of the requirements and characteristics for eligibility is given below.

Aid to Families with Dependent Children (AFDC)

AFDC is a cash assistance program which is jointly funded by the federal government and the state. Requirements for AFDC eligibility consist of: 1) unmarried pregnant females in their last trimester of pregnancy; or 2) a single parent family having at least one child under the age of 18 who is living with a relative and deprived of support. The deprivation can be caused by a parent or spouse that: was deported, died, deserted, divorced, left (separated), is incapacitated, is in jail or prison, is in a medical institution, or is a refugee. A condition of need must also exist. Need exists when a person does not have resources or income sufficient to provide a reasonable subsistence according to standards determined by SRS.

To determine whether a need exists, sources of income are evaluated. Gross monthly income, including earned and unearned income, is tested against a gross monthly income standard. The standard establishes the maximum amount of total monthly income households can receive. Income excluded from the gross monthly income test includes such items as child support payments, food stamps, Low Income Energy Assistance payments, and undergraduate student loans administered by the Commissioner of Education.

The illustration below is an example of the gross monthly income standard that cannot be exceeded for specific size households.

GROSS MONTHLY INCOME STANDARD

No. Of Persons In Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month
1	$ 474	$ 170
2	623	276
3	742	374
4	949	487
5	1,123	575
6	1,262	648
7	1,397	714
8	1,534	784
9	1,667	855
10	1,800	925

Source: AFDC Policy Manual, SRS

Illustration 3

If the household meets the gross monthly income test, the household's net monthly income is tested. The net monthly income standard represents the requirements the individual (or group of individuals) needs for basic subsistence (food, clothing, shelter, and other essentials). To arrive at net monthly income, three standard "disregards" are subtracted from earned income. Disregards are monetary amounts set by federal regulations. The three disregards are: 1) $75 work allowance; 2) day-care costs up to $160; and 3) $30 and one-third of the remaining income for four consecutive months and $30 for an additional eight months.

The following illustration is an example of the net monthly income that cannot be exceeded for specific size households.

NET MONTHLY INCOME STANDARD

No. Of Persons In Household	With Shelter Obligation Per Month	Without Shelter Obligation Per Month
1	$ 256	$ 92
2	337	149
3	401	202
4	513	263
5	607	311
6	682	350
7	755	386
8	829	424
9	901	462
10	973	500

Source: AFDC Policy Manual, SRS

Illustration 4

If the individual's income is below both the gross monthly income standard and the net monthly income standard, the person is income eligible for AFDC.

In addition to income standards, resources in AFDC households also cannot exceed certain levels. There is a general resource limit of $1,000 per household. The equity value of all property owned by the applicant or recipient, including income producing property, is included toward the $1,000. A home owned and occupied by the applicant or recipient is excluded regardless of value. One vehicle is excluded provided its equity value does not exceed $1,500. Household goods, clothing, and other personal effects, home produce for family use and consumption, and other similarly essential items of limited value are excluded. There is no definition of limited value. The face value of life insurance policies is excluded from the resource limit; however, the cash value is counted toward the general resource limitation.

The application of the resource and income limits is illustrated in the following example:

> A divorced woman with two children, aged three and five, applies for AFDC the first of the month. She owns and lives in her own home. She has no house payments. She does have a shelter obligation since home repairs, taxes, home

insurance, utilities, and other costs related to maintaining a home are considered shelter obligations. Her car has an equity value of $2,000; she has no other resources applicable to the $1,000 limit. Her furniture, clothing, kitchen utensils, washer/dryer, etc. are not included in the resource limit. The woman has a part-time job that pays her a gross monthly income of $700 and an income of $575 after deductions, such as taxes and F.I.C.A.

The first $1,500 of her car is excluded so $500 of the equity value is included in her general resources. She is still below the $1,000 limit so she is eligible for aid after the resource tests.

Her gross monthly income of $700 is compared to the standard for three people in a household with a shelter obligation, which is $742. Since her gross monthly income is less than the standard, she is still potentially eligible.

Her income is then tested against the net standard. Prior to comparison, a $75 disregard established by federal regulations plus day care expenses of $150, and the $30 disregard, also established by federal regulations, are subtracted from her gross monthly income. The remaining income ($445) is further reduced by one-third ($148), per federal regulations. Her net monthly income is now $297 and below the standard of $401, so she meets all the tests and is eligible for AFDC. The woman and her children also receive Medicaid benefits at this time.

Supplemental Security Income Program (SSI)

The SSI program is a federal cash assistance program, implemented to insure a minimum income for the aged, blind, or disabled. SSI originated in 1974, replacing separate old-age assistance, aid to the blind, and aid to the disabled programs. Each program was administered and partially financed by the states. Currently, the majority of SSI is financed by the federal government. The remainder is financed by states with state funds.

Eligibility for SSI is determined by the Social Security Administration. SSI eligibles fall within at least one of three categories: 65 or older, blind, or disabled. As with AFDC, resources and income cannot exceed certain levels. There is a $1,600 resource limit for an individual and $2,400 for a couple. Household goods and personal effects with an individual equity value of $2,000 or less are not counted. If total equity value of an item exceeds $2,000, the excess counts toward the total resource limit. The

market value of a car below $4,500 is excluded. A car is totally excluded if it is necessary for employment, transportation for the treatment of a medical problem, or modified for the transportation of a handicapped person. Also, ordinary life insurance with a face value of less than $1,500, and an irrevocable burial trust of less than $1,500, are excluded. A home (and adjacent land) which is the eligible's principle place of residence is not included as a resource.

An individual is eligible for SSI if his/her countable income is less than $325 a month; a couple is eligible with countable income less than $488 a month. Countable income includes anything received that can be used to meet the needs for food, clothing, or shelter.

The application of the resource and income limits is illustrated in the following example:

> A married couple are both over age 65 and apply for SSI. They own the home they are living in. The husband has an income of $450 a month from his Social Security benefit. Household goods all have a current value of less than $2,000. Their car is valued at $3,000.
>
> The car is not included toward the total resources allowed since the first $4,500 for a car is excluded. The couple is also below the total resource limit of $2,400 so they are eligible for aid after the resource test.
>
> The couple's countable income is tested next. Twenty dollars is subtracted from the monthly income, per federal regulations. The result is $430 which is below the income limit of $488. The couple is eligible for SSI and Medicaid benefits.

Recipients of SSI are also requested to provide information on third-party liability as a part of gathering information for Medicaid. A third-party is an individual, institution, corporation, or agency which may be liable to pay all or part of the medical cost of injury, disease, or disability of someone eligible for the Montana Medicaid program.

Medically Needy

Medically needy Medicaid coverage is an option for the states. Federal financial participation (FFP), though, is available to any

state which opts to extend coverage to this category of people. Once FFP is received, the state must adhere to basic guidelines for eligibility and benefits established by the federal government.

Medically needy are those individuals or families otherwise eligible for medical assistance but whose income is above the limits prescribed for the categorically needy. Medically needy eligibles are grouped with either AFDC or SSI, depending on which program's non-financial eligibility criteria are met.

Incurred medical expenses of the medically needy must be sufficiently high so payments in full would reduce the person's income to a level below "protected income" standards set by the state, based upon federal regulations. The following table contains an example of the amount of net income protected for maintenance by family size:

MEDICALLY NEEDY INCOME LEVELS

Family Size	Monthly Income Level	Quarterly Income Level
1	$ 314.00	$ 942.00
2	375.00	1,125.00
3	400.00	1,200.00
4	425.00	1,275.00
5	501.00	1,503.00
6	564.00	1,692.00
7	624.00	1,872.00
8	685.00	2,055.00
9	744.00	2,232.00
10	804.00	2,412.00

Source: ARMs

Illustration 5

All families are assumed to have a shelter obligation.

A "spend down" is also required of medically needy recipients. "Spend down" is incurring medical obligations to the extent the individual's income exceeds the medically needy income level. Once at the maintenance level, Medicaid will pay for the portion of medical bills not met by the individual, or by liable third parties such as Medicare or insurance companies.

The application of the resource and maintenance limits and spend down is illustrated in the following example:

> A mother of two children does not have health insurance. Her net income is $500 a month. She has no resources. Her car is valued at $500.
>
> Her income level exceeds AFDC standards for net monthly income, but her resources are under the $1,000 limit. One of her children receives medical treatment that if she had to pay will leave the woman without any money for food, shelter, clothing, etc. Since she does have some income, she has to incur allowable medical bills above a certain limit before Medicaid pays for services.
>
> This family is eligible for medical assistance when allowable medical deductions equal $300. To determine the amount of medical expenses to be incurred the monthly income is multiplied by 3 to find the quarterly income. This is $1,500. The medically needy income level for 3 for a quarter is $1,200. This is subtracted from the $1,500 to determine the medical increment amount of $300.

Other Eligibles

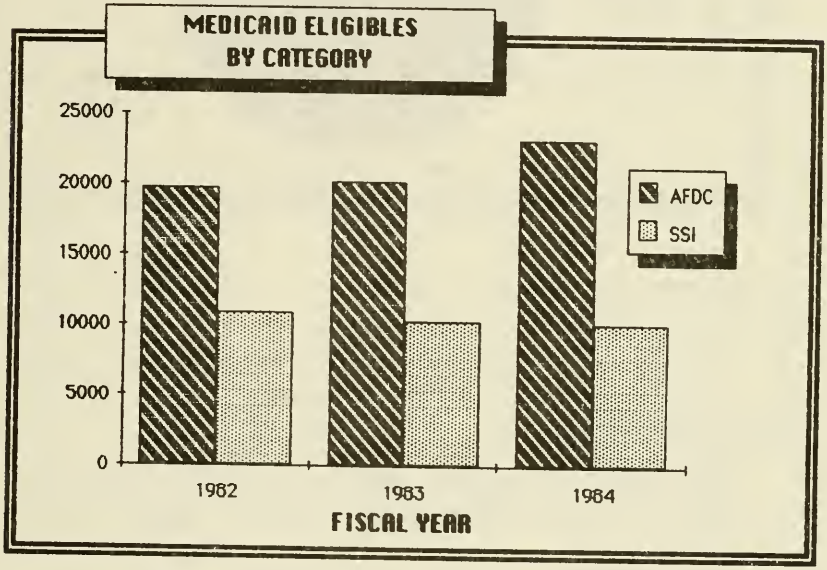
Two other groups receive additional exclusions when being determined eligible for Medicaid benefits: enrolled tribal members and refugees. Financial eligibility of enrolled tribal members is determined by the same standards used for all groups; however, enrolled tribal members are allowed to exclude certain income prior to application of the standards. One example is the exclusion of payment to the tribe for use of tribal land.

Refugees in the state are eligible for medical assistance under the "Refugee Assistance" program. All recipients must be residents of Montana and must have been admitted into the U.S. with permanent residence status. AFDC financial factors are used in determining the person's eligibility.

HOW MANY ARE ELIGIBLE

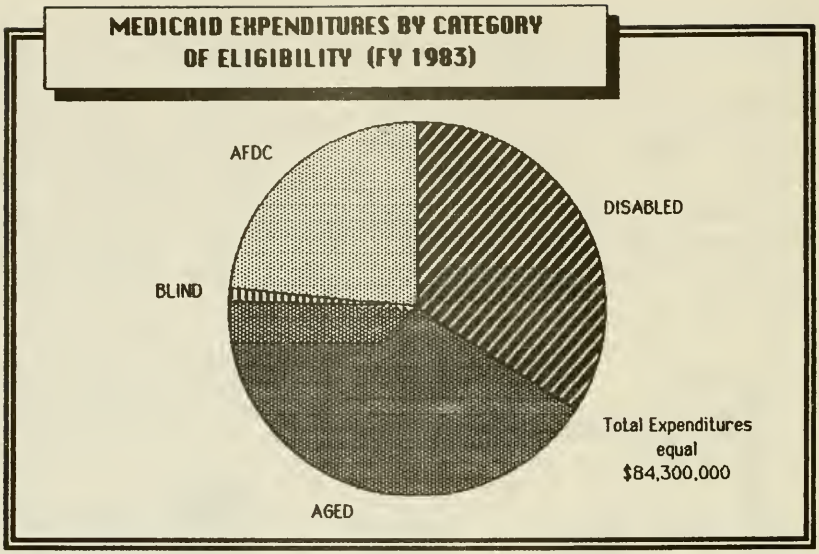
The number of eligible persons in the state of Montana has been increasing. An eligible is any person determined to be eligible for Medicaid benefits; whereas, a recipient is a person who

actually receives benefits. Illustration 6 shows the average number of people in Montana eligible for Medicaid for the past three fiscal years. The number eligible through AFDC is approximately twice that of SSI. However, Montana's SSI recipients (aged, blind, or disabled) account for approximately three-fourths of all Medicaid expenditures (see Illustration 7). This is caused by the more intensive care, such as nursing home care, required by SSI



Source: SRS Date of Service Reports

Illustration 6



Source: SRS Date of Service Reports

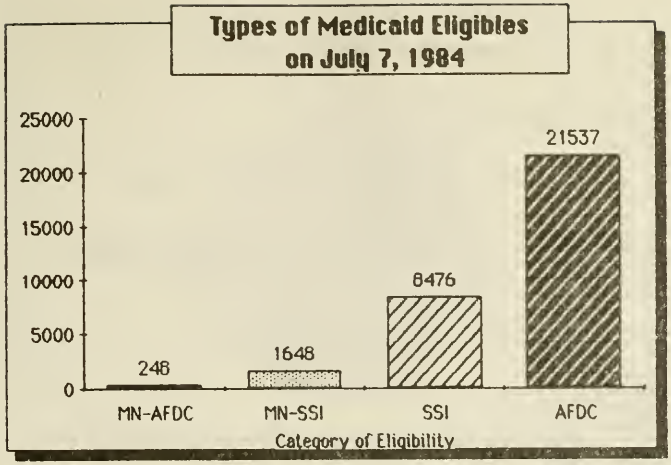
Illustration 7

TYPES OF ELIGIBLES

The following information provides information concerning the types of people eligible for Medicaid on July 7, 1984. Included are charts showing the numbers of categorically and medically needy eligibles; the number of Medicaid eligibles in nursing homes; the age distribution of eligibles; the sex distribution of eligibles; the number of applicants in fiscal year 1983-84; and the distribution of AFDC and SSI clients in Montana.

Categorically and Medically Needy

As stated previously, people eligible for Medicaid are either categorically or medically needy. The following chart details the number of categorically and medically needy (MN) Medicaid eligibles by type of eligibility. As can be noted, most people are categorically needy because they receive AFDC or SSI benefits.

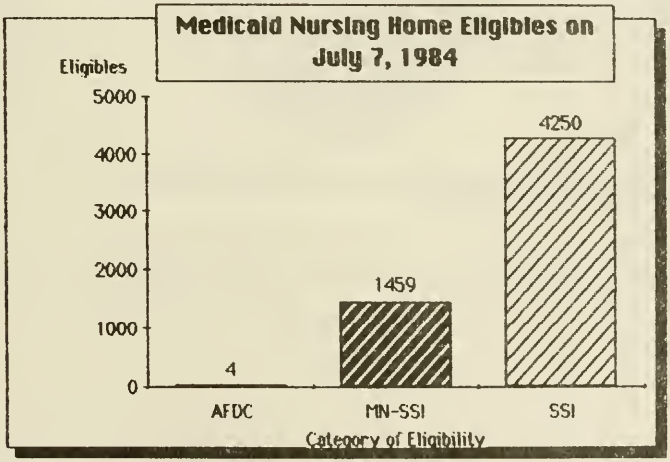


Source: Office of the Legislative Auditor from SRS records

Illustration 8

Nursing Home Eligibles

Approximately one-half of the SSI-related people eligible for Medicaid are in nursing homes. The following chart illustrates the breakdown of people eligible for Medicaid in nursing homes.

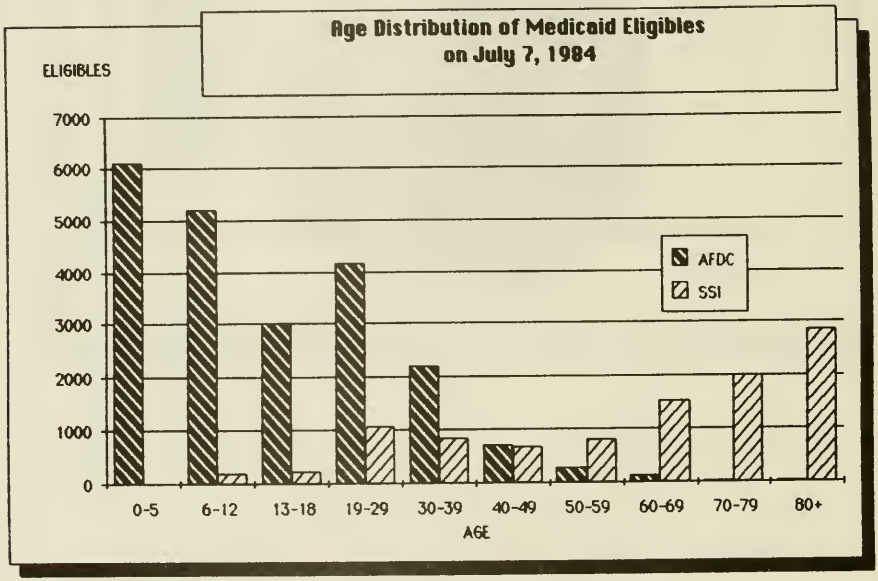


Source: Office of the Legislative Auditor from SRS records

Illustration 9

Age Distribution of Eligibles

The following chart details the ages of AFDC and SSI eligible people.

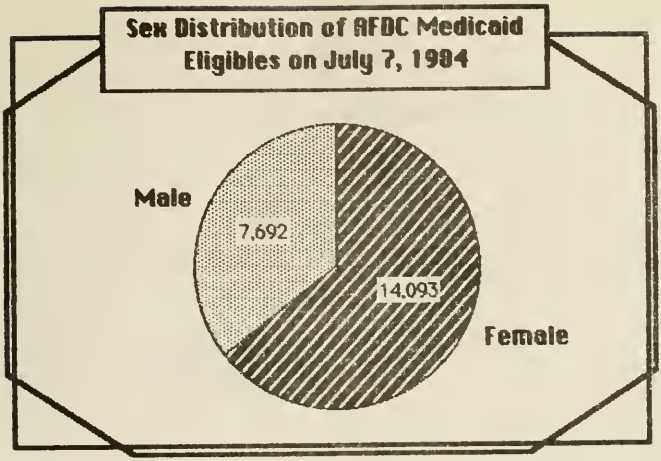


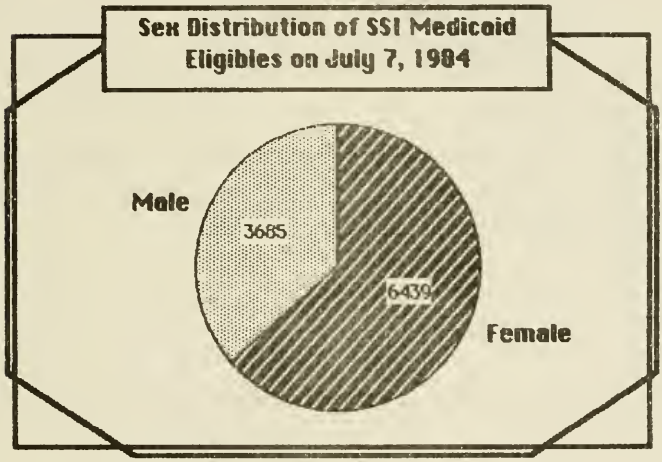
Source: Office of the Legislative Auditor from SRS records

Illustration 10

Sex Distribution of Eligibles

Sixty-four percent of Medicaid eligible people are female. The majority of these are eligible through AFDC. The following charts detail the distribution of males and females eligible for Medicaid.





Source: Office of the Legislative Auditor from SRS records

Illustration 11

Applicants

The following illustration depicts the number of applicants for AFDC and Medicaid in fiscal year 1983-84. The chart is broken

down into the number that applied for aid for the first time in fiscal year 1983-84, and the number that had been on aid prior to 1983-84, stopped receiving aid, and then reapplied in fiscal year 1983-84.

NUMBER OF APPLICANTS

	AFDC and AFDC-Related	SSI and SSI-Related
Applied for first time in fiscal year 1983-84	4,784	2,405
Had been receiving aid before and reapplied	657	183

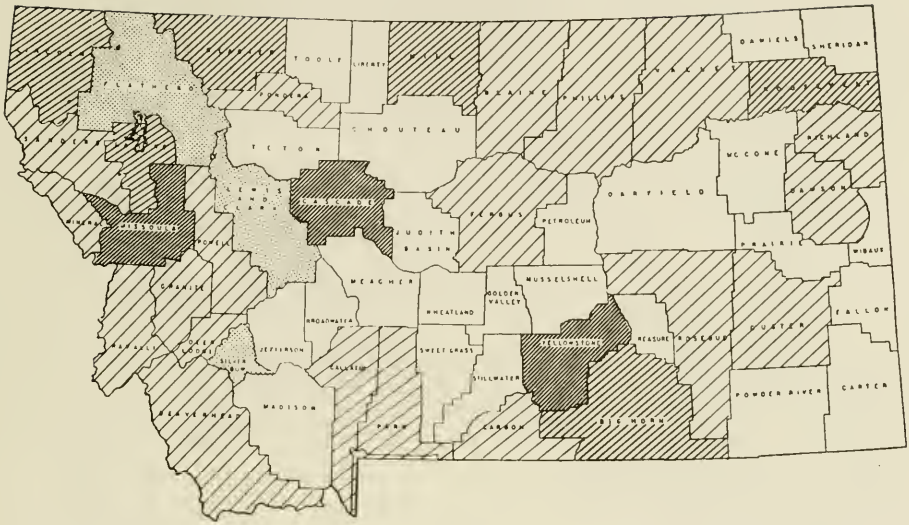
Source: Office of the Legislative Auditor from SRS records.

Illustration 12

Distribution of Clients

As would be expected, the more populated counties have the most Medicaid eligible people. The following maps detail the distribution of AFDC and SSI clients in Montana.

DISTRIBUTION OF AFDC CLIENTS



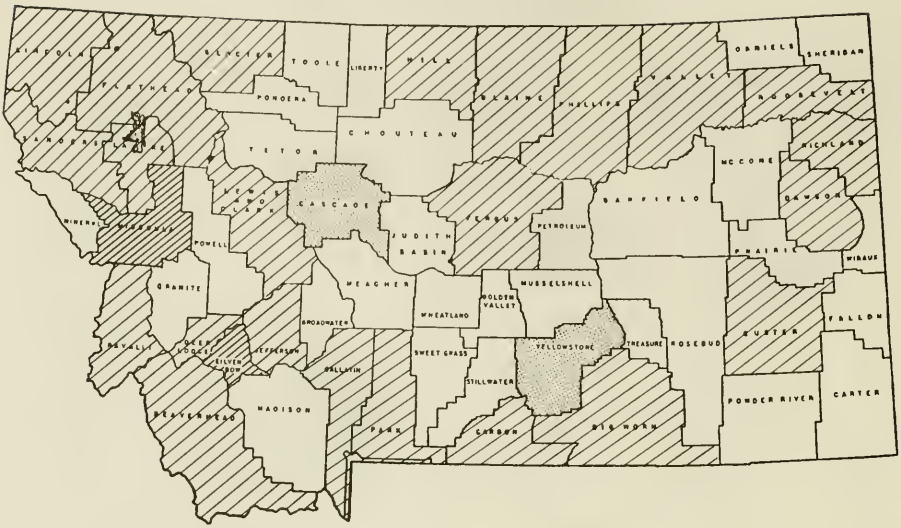
Legend

- 0 to 100
- 101 to 600
- 601 to 1000
- 1001 to 2000
- Over 2000

Source: Office of the Legislative Auditor from SRS records

Illustration 13

DISTRIBUTION OF SSI CLIENTS



Legend

- 0 to 100
- 101 to 600
- 601 to 1000
- 1001 to 2000

Source: Office of the Legislative Auditor from SRS records

Illustration 14

ROLES OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES AND THE COUNTIES

The Montana Medicaid program is administered at the state level by SRS and at the local level by county welfare departments. Five bureaus at SRS provide administrative support to the counties. The following is a brief description of each bureau's role as it relates to Medicaid.

-Field Services Bureau
Works with local welfare departments and county commissioners to serve recipients of public assistance programs.

-Eligibility Policy Bureau
Responsible for developing eligibility policies and procedures in accordance with state law and/or federal regulations, and which are administratively feasible given the reporting needs and limitations at the county level.

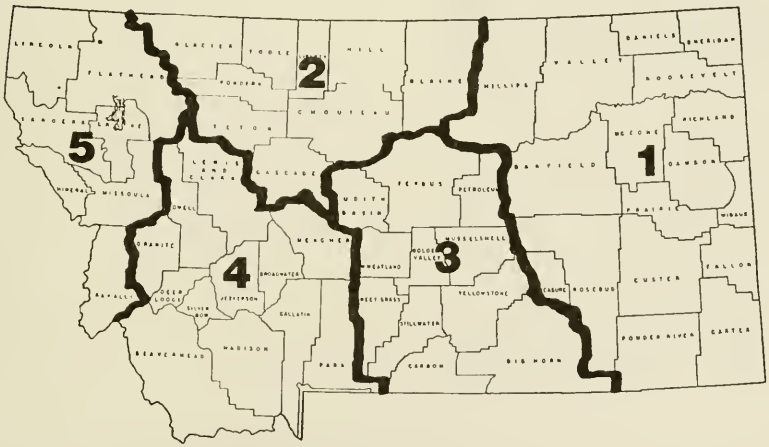
-Management Operations Bureau
Provides data processing coordination between SRS and counties.

-Data Processing Bureau
Provides data processing and programming support to the Management Operations Bureau.

-Program Integrity Bureau
Provides for quality control reviews.

Within the Field Services Bureau are five field supervisors. The field supervisors act as liaisons between the department and county welfare departments and county commissioners. Each supervisor is responsible for seven to sixteen counties. The following map details the five regions the field supervisors administer.

REGIONS FOR WELFARE ADMINISTRATION



Source: SRS records

Illustration 15

At the county level, the county Departments of Public Welfare administer public assistance operations. In 1983 the Legislature enacted legislation allowing counties to transfer the administration of public welfare programs to the state. Counties opting for state assumption must levy 12 mills annually to pay expenses of the public assistance program. Twelve counties opted for the state to administer their public welfare programs. In these counties SRS assumed responsibilities for public assistance and protective services previously provided by county departments. The twelve counties include: Cascade, Deer Lodge, Flathead, Lake, Lewis and Clark, Lincoln, Mineral, Missoula, Park, Powell, Ravalli, and Silver Bow.

The following chart summarizes and compares the general responsibilities of assumed and non-assumed counties.

GENERAL RESPONSIBILITIES OF ASSUMED AND NON-ASSUMED COUNTIES

Assumed

1. SRS assumes authority to establish and operate a public assistance program and provide protective services for children and adults.

2. SRS selects, appoints, and supervises all necessary public assistance and protective service personnel, including, if necessary, a supervisor of staff personnel. All personnel are directly responsible to the department.

3. The county attorney is to provide legal assistance and representation for purposes of adult and child protective services.

Non-Assumed

1. Each county shall have a county Department of Public Welfare which consists of a county Board of Public Welfare and necessary staff.

2. The Board of County Commissioners is the ex-officio county welfare board.

3. The county board hires staff personnel from a list of qualified persons furnished by SRS.

4. The staff is directly responsible to the county board.

5. The county board cannot dismiss someone without going through SRS.

6. The county Department of Public Welfare is charged with local administration of all forms of public assistance in the county including food stamps and social services programs.

7. The county Board of Public Welfare is responsible for establishing local policies and rules as necessary to govern the county department and local administration of public assistance activities (all policies and rules must conform with the general policies and rules established by SRS).

Source: Office of the Legislative Auditor from Title 53, chapter 2, part 3, MCA.

Illustration 16

Staffing

County directors provide daily supervision of staff. Directors are responsible for coordinating all aspects of public assistance programs in the counties to ensure clients and the community are served effectively. Directors conduct information and/or training sessions for community groups concerning public welfare programs. Some county directors also perform social work duties, such as investigating cases of child abuse and/or neglect. There are thirty-four county directors; twelve are responsible for operations in two or more counties.

Counties with larger populations have eligibility technician supervisors to assist in the eligibility determination process. Eligibility technician supervisors provide direct supervision to eligibility staff. Supervisors direct work assignments, review staff work, and evaluate performance. They also interpret policy and provide procedural instruction through individual and group meetings.

Eligibility technicians determine clients' initial and continuing eligibility for all public assistance programs. Eligibility is determined through interviews with clients and others, evaluation of documents and records, and other means. (The process is described in detail in Chapter IV.)

Counties with larger populations also have clerical staff. These people type letters, file records, answer the telephone, distribute applications, and make appointments for the clients to see eligibility technicians.

The following chart indicates the counties with directors, eligibility technician supervisors, and the actual number of technicians in each county on October 1, 1984. Since not every county has a caseload requiring a full-time position, some technicians travel between counties.

STAFF BY COUNTY

County	County Director[1]	Eligibility Technician Supervisor[1]	Actual Number of ET FTE Employed
Beaverhead	X		1.00
Big Horn	X	X	4.00
Blaine			3.00
Broadwater	X**		1.00**
Carbon	X		2.00
Carter			.20
Cascade	X	X	18.00
Chouteau	X		.50
Custer	X*		1.60
Daniels			.25
Dawson	X*		1.00
Deer Lodge	X	X	4.00
Fallon	X*		.20
Fergus	X*	X	2.95
Flathead	X	X	11.00
Gallatin	X		5.00
Garfield			.20
Glacier	X	X	6.00
Golden Valley			.20
Granite			.60
Hill	X*	X	5.84
Jefferson	X		1.00
Judith Basin			.50
Lake	X	X	5.00
Lewis and Clark	X	X	10.50
Liberty			.16
Lincoln	X	X	6.00
Madison	X		1.00
McCone			.40
Meagher			1.00
Mineral	X		1.00
Missoula	X	X	19.00
Musselshell			1.00
Park	X*		3.00
Petroleum			.05
Phillips			1.00
Pondera	X*		2.00
Powell	X*		1.60
Powder River			.20
Prairie			.60
Ravalli	X	X	6.00
Richland	X		2.00
Roosevelt	X*	X	3.00
Rosebud	X*		2.82
Sanders	X		2.00
Sheridan			.75
Silver Bow	X	X	10.00
Stillwater			1.00
Sweetgrass	X*		1.00
Teton			1.00
Toole			1.00
Treasure			.18
Valley	X*		3.00
Wheatland			.80
Wibaux			.60
Yellowstone	X	X	18.00
Total	34		176.70

*Denotes county director is responsible for more than one county
**County director determines eligibility of clients. A separate position is not allocated for an eligibility technician.

Source: 1) SRS records
2) Office of the Legislative Auditor from information submitted by county directors

Illustration 17

Approximately 176 FTE were authorized for ET positions in fiscal year 1984-85.

CHAPTER III

EFFICIENCY OF ELIGIBILITY DETERMINATION

In our audit we focused on the processes used in the counties to determine eligibility. We reviewed procedures and documents to conclude whether eligibility determination is consistent, and what information the eligibility technicians (ETs) use to determine eligibility of clients. We found the general process used by ETs in their determinations of eligibility is consistent; however, the actual office procedures may differ between counties. We also noted consistent deficiencies in the counties in that verification of applicant resources is minimal, home visits are seldom conducted, and some necessary signatures are not obtained.

We found some procedures and use of information could be more efficient. Counties are operating with procedures developed through trial and error. These procedures could be more efficient, thus giving ETs more time to determine eligibility.

SRS has provided minimal guidance to the counties concerning how to operate efficiently, either in the processes used or information distributed. For example, SRS knows ETs have many forms to use, and the duties of one person in the Economic Assistance Division include redesigning forms. Some forms used for state assistance programs in state-assumed counties have been redesigned and consolidated, but nothing has been done to consolidate what appears to be duplicate information on a number of forms used for federal programs and county programs in non-assumed counties. Another example concerns computer generated information SRS distributes to the counties to provide information concerning client's eligibility. SRS obtained information from ET supervisors concerning how to modify the computer printouts so the printouts would be more useful to ETs. SRS has still not utilized the information.

We believe SRS could help the counties more efficiently organize offices, per a state statute which directs the department to ". . . provide services in respect to organization and supervise county Departments of Public Welfare and county Boards of Public

Welfare in the administration of public assistance functions and for efficiency and economy." (53-2-201, 1(e), MCA.)

The issues to be discussed in Chapters IV through VIII of this report indicate a need for SRS to take a more active role in the management of the eligibility determination process. The following issues illustrate our individual concerns:

Concern	Chapter
1. Verification of resources and home visits	IV
2. Consolidation of forms	IV
3. Use of important forms	IV
4. SRS's administrative role in the eligibility determination process	IV
5. Timeliness of policy creation	V
6. Receipt of policies	V
7. Timeliness of appeals	VI
8. Computer reports used in the counties	VII
9. Controls over computer information	VII
10. Efficiency of county welfare offices	VIII

Overall, we believe SRS could improve the eligibility determination process by more actively managing the program in the counties.

RECOMMENDATION #1

WE RECOMMEND SRS TAKE A MORE ACTIVE ROLE IN MANAGING THE ELIGIBILITY DETERMINATION PROGRAM.

CHAPTER IV

ELIGIBILITY DETERMINATION PROCESS

During our audit, we reviewed how the initial eligibility determination and redetermination processes are conducted. We examined documentation which is used by eligibility technicians (ETs) to aid in the determination of eligibility and the procedures followed concerning verification of information. Overall, we determined the processes are functioning adequately. We did find specific areas in which the processes could be improved. The following sections of this chapter describe the processes and discuss areas for improvement.

INITIAL DETERMINATION PROCESS

The initial determination process begins by an applicant requesting assistance. Depending on the county, the applicant may see an eligibility technician (ET), or clerical staff may assist in the distribution of the appropriate application. The applicant fills out the forms and is then interviewed by an ET. At this time the ET determines the type of assistance needed; explains programs available; explains the client's rights and responsibilities; completes additional forms; and requests necessary verification the client has not already produced. Required information includes Social Security cards and birth certificates, or other proof of age and relationship for all members of the household receiving aid. If a person does not have a Social Security number the ET will help the applicant complete the appropriate form and instruct the applicant to send the form to the Social Security Administration. Other required information includes shelter receipts to verify the place of residence; any divorce decrees or marriage certificates; proof of any income; bank statements; insurance policies; vehicle registrations; property records; Indian tribal membership documents; and any other documents the ET may need to determine eligibility.

The ET then has 30 days to determine whether the client is eligible for Aid to Families with Dependent Children (AFDC) and

45 days to determine eligibility for other Medicaid applicants. Federal regulations impose the time limitation. During the time limit the ET reviews information and documents verification; makes personal contacts if necessary; and determines whether or not the client is eligible. A case record is then compiled. If the county is not state-assumed, the ET presents the case to the county welfare board for review and approval. ET supervisors or county directors will usually review the case in state-assumed counties.

If the person is deemed eligible, a Medicaid card is issued by the county. All succeeding cards are generated at the state level.

Supplemental Security Income (SSI) eligibility is determined by the Social Security Administration. Information pertaining to an eligible client is sent to the county in which the client resides.

REDETERMINATION PROCESS

Client's eligibility must be redetermined in a specified time period. Federal regulations require AFDC recipients to be redetermined for eligibility every six months, and SSI recipients must be redetermined at least every twelve months. The redetermination process consists of the ET collecting and reviewing any necessary information to ensure the client is still eligible. Information collected consists of a form indicating changes in address, household composition, income, and assets. ETs verify the information through documentation submitted by the client and by information from the Department of Labor and Industry concerning unemployment benefits, workers' compensation, and wages paid to the client. Any necessary changes are made in eligibility and the client is notified.

ELIGIBILITY PROCEDURES

During our audit we visited thirteen county offices to determine if ETs across the state determine initial and continuing eligibility consistently and use the same general methods. Our review indicated ETs are consistent in their initial and continuing determinations and use virtually the same general methods.

We also reviewed the timeliness of processing applications and redetermining eligibility. Of 330 cases reviewed, 70 had been opened in the last six to twelve months. All 70 cases had eligibility determined within the prescribed time limits. The remaining 260 cases reviewed required redetermination. We found only four cases were not redetermined in a timely manner. We reviewed the untimely cases and found, despite the delay, eligibility had not changed since the last determination. Based on the information gathered we conclude initial determination and redetermination of eligibility are completed in a timely manner.

Even though the determinations are timely, we did identify concerns pertaining to the procedures and information used. These are discussed below with our recommendations.

Verification of Resources

During the initial eligibility determination process and the redetermination of eligibility, clients are asked to disclose in writing any assets or resources. The ET then attempts to verify any items listed. If a car is listed, for example, the ET will obtain a copy of the registration slip. ETs do not routinely check for resources the client does not report. A large percentage of clients list no resources. Of 330 client files we reviewed, 161 clients reported they had no resources or assets.

In some counties ETs will attempt to identify assets (checking and savings accounts, safety deposit boxes, etc.) at local financial institutions. Clients must sign a release of confidential information form and this will be circulated to financial institutions. Information from financial institutions is not gathered for every client. In counties with larger numbers of people on aid, information is gathered for only those clients believed to be withholding information. In counties with smaller populations ETs do not like to circulate the forms because the people in town would then know the person has applied for, or is receiving, aid. Counties have also found some financial institutions are reluctant to provide the information because the institutions are not reimbursed for the service.

During the redetermination process ETs have computer matches available indicating unemployment compensation, wages, and workmen's compensation paid to clients. SRS is currently seeking legislation that will allow it to access specific information obtained by the Department of Revenue. The pending legislation allows SRS to gather information pertaining to monetary distributions to recipients of public assistance upon which no withholding tax has been deducted. This information includes: 1) sums in excess of $10 distributed as dividends, interest, and payments made under a retirement plan covering an owner-employee; and 2) rents, royalties, salaries, wages, prizes, awards, annuities, pensions, and other fixed or determinable gains, profits, and income in excess of $600.

We also found ETs conduct very few home visits. Department personnel said home visits are not conducted because it is hard to find clients at home, even when an appointment has been made; or if the client is home he/she will not answer the door. For the most part, ETs indicated they do not conduct home visits because they do not have the time. Home visits were conducted when caseloads were lower according to ETs. Some visits are still made if the ET has time and the client appears to be withholding information.

We surveyed seven western states to determine if ETs in other states conduct home visits. We found three states routinely have ETs conduct home visits and find them beneficial in identifying undisclosed resources, additional information, and the presence of the "absent" spouse. Other states no longer conduct visits because caseload has increased. Personnel interviewed in these states indicated they would like to have home visits resumed. They believe the visits are helpful to the ETs, and clients are less liable to defraud the system.

The information provided us by our county visits indicates ETs rely almost entirely on what the clients tell them during the initial determination process. If the client fails to tell the ET about any assets or resources, the ET will rarely become aware of the asset or resource.

Verification is an essential control in the determination process. Under current operating conditions, little or no verification of unreported resources is being conducted. The stated cause is lack of time and cooperation. We attempted to determine the effect on the Medicaid program of not verifying certain information. (Other welfare programs will also be impacted by lack of verification.) We could not determine whether there is any effect due to the lack of verification of resources. SRS Quality Control reviews of cases indicate resource errors account for 18.6 percent of total errors. (The Quality Control program will be reviewed in a future audit.) There is a potential effect of clients receiving benefits when they are not eligible.

The problem can be addressed by providing ETs more information. Home visits can provide information concerning undisclosed or additional resources. The pending legislation with the Department of Revenue will provide ETs with information pertaining to some monetary assets clients may not have disclosed.

RECOMMENDATION #2

WE RECOMMEND THE DEPARTMENT CONTINUE ITS EFFORTS TO INCREASE THE INFORMATION AVAILABLE TO ELIGIBILITY TECHNICIANS TO VERIFY INFORMATION PROVIDED BY CLIENTS.

Consolidation of Forms

We asked the ETs in the counties visited to provide us with the informational sheets they distribute to applicants, and the forms they must use to determine eligibility, verify and/or obtain information, open or close a case, etc. Sixty different forms and informational sheets were obtained for the AFDC and Medicaid programs. Additional forms are used for Food Stamps and state and county assistance programs. Department personnel informed us ETs normally handle over 150 forms in the course of their work.

Some of the forms and informational sheets contain or require virtually the same information. For example, clients are provided with a sheet detailing what verification they need to provide the ET during the initial interview. We found some counties use five sheets for five different assistance programs. Sheets for three of the programs include almost the same information. The following illustration compares the information on the three sheets.

COMPARISON OF INFORMATION ON SHEETS

Information on Sheet	Program AFDC	Food Stamps	State Medical
I.D. with picture	yes	yes	yes
Social Security cards	yes	yes	yes
Sources of income	yes	yes	yes
Current balances of checking and savings accounts, also value of stocks, bonds, C.D.s	yes	yes	yes
Rent or house payments	yes	yes	yes
Birth certificate	yes	yes	no
Registration slips on all vehicles	yes	yes	no
All current utility bills	yes	yes	no
Educational grants, scholarships, and student loan information	yes	no	yes
Third-party liability information	yes	no	no
Verification of day-care paid out	yes	no	no
Verification of separation or divorce	yes	no	no
Medical expenses if applicant over age 60, or receives SSI or SSA disability payments	no	yes	no
Current medical bills	no	no	yes

Source: Office of the Legislative Auditor from county records

Illustration 18

The three sheets could be combined into one, with information applicable to all programs listed first, then information pertaining to individual programs listed under appropriate headings. When

the sheet is distributed to the client the person handing out the sheet could highlight the additional information needed for the specific program(s) for which the person is applying.

In October 1983 the department circulated a memo to all county directors in state assumed counties asking them to send in copies of all county forms they use. The memo stated they were attempting to standardize county forms. Some forms concerning state assistance programs were redesigned but nothing has been done in non-state assumed counties or with federal programs (AFDC, Medicaid, food stamps). Department personnel indicated forms have not been consolidated because other problems, such as rewriting AFDC and general assistance policies, have taken precedence. They plan on selecting a task force to review the forms and determine if any can be consolidated and/or redesigned. In our visits to the counties we found ETs and ET supervisors supportive of form redesign and consolidation. Department personnel are not sure whether county forms will be included in the process since they believe they have little or no control over non-state assumed counties.

We believe all the forms used by the ETs should be reviewed and consolidated and/or redesigned. Consolidating and redesigning forms so they are efficient, and not excessive in number, could help reduce the time spent on completing forms and workers would have more time to do their other duties.

All forms should be included in the consolidation process since some of the county forms also ask for information contained on the state forms. County directors could be asked to help, thus soliciting their cooperation in the inclusion of county forms in the consolidation process.

RECOMMENDATION #3

WE RECOMMEND THE DEPARTMENT REDESIGN AND CONSOLIDATE THE FORMS USED BY ELIGIBILITY TECHNICIANS.

Eligibility Intake Checklist

The eligibility intake checklist form is to be used by the ET during the process of initial eligibility determination for Medicaid benefits. The form requires the ET to:

- briefly state the applicant's need for help;
- explain the client's rights and responsibilities;
- review all completed forms; and
- discuss with the client the other programs and benefits available to the client.

The form has a space for the client's signature, indicating the above items have been completed and the client understands his/her rights and responsibilities.

During our review of the files we found the eligibility intake checklist is not consistently used. Some ETs use the form for every client, some use it upon occasion, and some never use it.

The AFDC eligibility policy manual states: "The applicant shall review the form and if satisfied with the information conveyed to him/her, sign and date the checklist form." The Administrative Rule (46.10.201 ARM) states: "During the first interview, the staff member has the responsibility to explain the person's rights, outline his responsibilities. . ." By having the client sign the form, the ET, and the department, have evidence the client was informed of his/her rights and responsibilities.

ETs indicated to us they do not use the form if they are busy because it is "just one more form." We were also told ETs had no need to use the form because they know what they are supposed to do and tell the client. It appears ETs do not understand the need for the form or the need for the client's signature indicating the client is aware of his/her responsibilities. We recommend the department explain to the ETs the need for the form (or a similar form explaining rights and responsibilities) and the need for the client's signature on the form. ET supervisors

could ensure ETs are obtaining the signature on the form by periodically reviewing a sample of new cases.

RECOMMENDATION #4

WE RECOMMEND THE DEPARTMENT:

A. EXPLAIN THE NEED OF THE ELIGIBILITY INTAKE CHECKLIST FORM TO THE ELIGIBILITY TECHNICIANS; AND

B. REVIEW A SAMPLE OF CASES TO ENSURE ELIGIBILITY TECHNICIANS ARE OBTAINING THE CLIENT'S SIGNATURE ON THE FORM.

SRS' ADMINISTRATIVE ROLE IN THE ELIGIBILITY PROCESS

In our review of SRS records we noted there is information available pertaining to the eligibility process SRS does not appear to be using. The following sections discuss our findings in this area.

Number of Mistakes on Turnaround Documents

Eligibility information is submitted to SRS, from the counties, for input onto the Montana Income Maintenance System (MIMS). (This system is discussed in detail in Chapter VII.) The information is submitted on turnaround documents (TADs). If the information input to the system from the TAD is not correct, a specific message is generated. For example, if the date for the month of opening the case is not 01 to 12, a message will be generated for that TAD stating the problem. A composite listing of how many mistakes occurred on the TADs in each county each month is generated for use at SRS.

We compared the number of mistakes occurring between April and August 1984. We found the number of mistakes occurring on TADs decreased from 26,326 mistakes in April to 6,157 mistakes in August. This is a decrease of approximately 77 percent.

In reviewing why the mistakes decreased overall, we noticed fluctuations in the number of mistakes occurring in the months

between April and August. For example, we found an increase in mistakes between June and July. In twenty-eight counties the number of mistakes increased by at least a third, or doubled. We questioned SRS personnel as to why the number of mistakes would have gone up; we wondered if there had been a change in policy or some other type of change. It became evident SRS personnel do not routinely monitor this information for management purposes since no one was aware the number of mistakes had gone up in these months or why. SRS personnel did compare the number of mistakes made in June to the number made in September to determine if the number of mistakes were decreasing, but the reports are not routinely reviewed and compared.

Demographical Information

We asked SRS personnel for information concerning the ages and distribution of people eligible for Medicaid. We were interested in the average age of a recipient, the typical composition of a recipient's household (for example, number of children, ages, etc. in an AFDC household, the number of people moving from county to county, age of nursing home population, etc.). Department personnel informed us they do not have such information. They were able to provide us with information gathered two years ago, but they do not periodically assemble demographical information.

Conclusion on Use of Information

SRS has information available concerning numbers of mistakes that are occurring that could be beneficial in expediting the eligibility determination process. This information is not being used to pinpoint problems ETs could be having in efficiently completing necessary forms. SRS also gathers information pertaining to the composition of eligible recipients which it does not utilize. This information could be used to determine whether the age distribution or household is changing, thus possibly indicating a future

increase or decrease in Medicaid payments, changes in types of clients, etc. This information is currently available on MIMS and can be extracted.

SRS priorities have not been directed toward using available information to prevent and/or identify problems or monitor the client population.

RECOMMENDATION #5

WE RECOMMEND THE DEPARTMENT USE AVAILABLE INFORMATION TO:

A. IDENTIFY PROBLEMS ETS COULD BE HAVING IN COMPLETING FORMS; AND

B. MONITOR THE ELIGIBLE POPULATION.

CHAPTER V

DEVELOPMENT OF POLICIES

The Eligibility Policy Bureau develops policies and procedures for determining eligibility in accordance with state and federal laws. These policies are intended to ensure proper determination of eligibility for all economic assistance programs.

The bureau has a staff of five: the bureau chief; two employees working directly with the Medicaid program, one employee with AFDC, and one with food stamps. Their main functions include:

1. Developing and updating economic assistance manuals for use by county welfare offices.

2. Training county eligibility technicians (ETs) on the proper eligibility determination for economic assistance applicants.

3. Researching information sources to clarify specific questions from ETs and program participants.

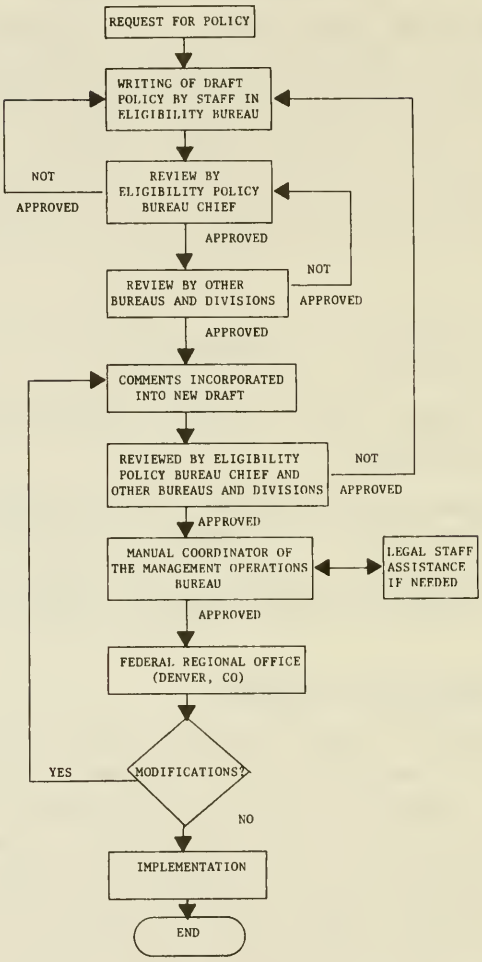
4. Translating, developing, and coordinating policies in compliance with state laws and federal regulations.

POLICY DEVELOPMENT PROCESS

Requests for policy development come from various sources including the federal government, program providers, and county personnel. Sixty-seven new or revised policies were mailed to the counties during the first six months of 1984. Federal government requests account for over 75 percent of the changes.

As the policy bureau receives requests for policy development, they discuss interpretations and the impact of the policy on the department budget and the eligibility process. The staff then develops a draft policy. Once the policy is developed by the bureau's staff it goes through a series of reviews by other bureaus in the Economic Assistance Division and other bureaus and divisions in the department. This process is intended to help ensure proper implementation of policies. The following illustration depicts the completed process of policy development.

POLICY DEVELOPMENT PROCESS



Source: Office of the Legislative Auditor

Illustration 19

During our audit of policy development we reviewed who is involved in policy development, timeliness of policy creation, and

how new policies are communicated to county staffs. The following sections discuss these issues.

Timeliness of Policy Creation

We found county staffs are receiving new policies after the date the policy is to be implemented. Of 67 policies that were mailed to the counties in the first two quarters of 1984, only three policies were mailed to the counties before the implementation date. The remaining 64 policies were mailed to the counties after they were to have been implemented by the county staff.

We believe federal and state procedures were equally responsible for the delay in counties receiving new policies. For about 50 percent of the changes SRS was not given adequate notification of necessary policy changes by the federal government. We compared SRS's receipt of notification of a policy change from the federal government to the implementation date for 23 changes in fiscal years 1982-83 and 1983-84. The following illustration details our findings.

Timeliness of Notification of Changes

	1982-83	1983-84
Received by state more than one month before implementation date	4	4
Received by state less than one month before implementation date	3	3
Received by state after implementation date	3	6
Total changes reviewed	10	13

Source: Office of the Legislative Auditor from SRS records

Illustration 20

The three changes received after the implementation date in 1982-83 were received by SRS 7, 34, and 68 days after they were

to be implemented. The six in 1983-84 were received 4, 8, 20, 33, 42, and 48 days after the implementation date.

A backlog of policy work at SRS's Eligibility Policy Bureau caused some delays in mailing policies to counties. Part of the delay at the state level also stems from the fact any bureau affected by a policy change is asked to review and comment on every draft of the policy before it is finalized. This process of policy review by other bureaus is time consuming.

During the portion of the audit concerning policy development, we intended to determine the actual input by those involved in the creation of a policy. We found the department does not keep records of any part of policy development. The initial document requiring a policy change is filed and the final draft is incorporated into the policy manual. Other working documents substantiating the creation of policy are destroyed. We also found there is no cross-referencing system between the initial document requiring a policy change and the policy incorporated into the manual.

The Eligibility Policy Bureau recently established a procedure in which various bureaus are given both minimum and maximum time limits in which to comment on a policy. SRS officials believe this will decrease the amount of time it takes to create and implement a policy.

Receipt of Policies

While in the counties we reviewed policy manuals to determine if all appropriate staff are receiving the policies. We found not all ETs had up-to-date Medicaid and AFDC policies. ETs in five of thirteen counties were missing one or more of the policies. A tracking system had been devised by the policy bureau to ensure ETs had all policies. The county directors are required to sign a sheet indicating everyone has the policies within their counties. It appears the system is not effective in every county. For example, we found one county did not return the sheet to the department.

SRS did not know why some people would not have the policies and did not realize one county had not returned the signed sheet.

We also noted ETs did not always have the policies in their manuals. If the policies are not in the manuals the policies could get lost, thrown away, and eligibility could be determined incorrectly.

SRS should revise its current procedure for ensuring ETs receive all the policies issued since current procedures do not appear to be working adequately. We suggest ET supervisors (in the counties with this staff) or field supervisors (in counties without an ET supervisor) routinely review policy manuals to ensure all the policies have been received and are in the manuals.

RECOMMENDATION #6

WE RECOMMEND THE DEPARTMENT TAKE STEPS TO ASSURE:

A. EVERYONE IS RECEIVING POLICIES; AND

B. POLICIES ARE BEING PLACED IN THE MANUALS.

BULLETINS

Bulletins are utilized by the Eligibility Policy Bureau as a means of quickly informing field staff of changes in policy. Field staff are instructed to follow bulletins until they are replaced with policies. The policies are then incorporated into the manual and the bulletins are removed. According to a SRS policy, bulletins are to be replaced with a formal policy within four months from the date the bulletins are issued.

In our visits to the counties we found the Eligibility Policy Bureau is not following its policy of updating bulletins within four months of the date they are issued. We found two bulletins in the AFDC policy manual issued in 1979 and 1981. One dealt with transferring of cases between counties, and the other with day care expenses.

This situation has created some confusion in the field because ETs are not sure whether they are to follow bulletins after the four months has elapsed or if they are to revert to the old policy.

We suggest SRS review its policy concerning updating bulletins. If bulletins do not need to be updated every four months, SRS should change its policy. If bulletins need to be updated, SRS should comply with the existing policy. The ETs should be informed of SRS's decision so there will be no confusion as to whether bulletins are to be followed.

RECOMMENDATION #7

WE RECOMMEND THE DEPARTMENT REVIEW ITS POLICY CONCERNING UPDATING BULLETINS TO DETERMINE WHETHER THE CURRENT POLICY IS NEEDED.

CHAPTER VI

APPEALS PROCESS

The Code of Federal Regulations and the Administrative Rules of Montana require the state to provide an opportunity for "fair hearing" to any applicant whose claim for financial or medical assistance is denied or not acted upon with reasonable promptness, and to any recipient who is aggrieved by any agency action resulting in reduction, discontinuance, or termination of assistance. The Department of Social and Rehabilitation Services (SRS) employs one full-time person to conduct hearings. An employee in SRS's office of legal affairs also conducts hearings if needed.

FAIR HEARING PROCESS

The fair hearing process includes an administrative review in which the claimant and county director discuss the case and findings. If the complaint is not resolved during the review the case will go to a fair hearing. Included in the hearing are a hearings officer, county director and/or eligibility technician supervisor of the county where the complaint originated, the claimant, and the claimant's legal representative (if the claimant has retained someone). The majority of hearings are conducted by telephone conference calls.

Based upon facts found during the hearing, the hearings officer makes a ruling on the case concerning the validity of the determination. Claimants who are dissatisfied with the findings of the hearing may request the case be reviewed by the Board of Social and Rehabilitation Appeals. The board is composed of the director of SRS and two members of the general public appointed by the Governor.

The results of the hearing are distributed to the county involved in the hearing, the claimant, and to the claimant's legal representative (if applicable). The remaining counties receive a copy after specific names have been deleted.

NUMBER OF APPEALS

Fair hearings are conducted for all county, state, and federal public assistance programs. The number of fair hearing requests has increased over the past five fiscal years. There were 311 requests in 1979-80 and 713 in 1983-84. SRS officials indicated the greater number of applicants and increased awareness of an individual's right to a hearing are possible causes for the rise in requests for hearings. The following illustration details the number of requests for hearings, administrative reviews, and fair hearings by type of aid for fiscal years 1982-83 and 1983-84.

FAIR HEARING DATA BY CATEGORY OF AID

	AFDC		Medical Assistance		County Medical		Medically Needy		Other*		Total	
	82-83	83-84	82-83	83-84	82-83	83-84	82-83	83-84	82-83	83-84	82-83	83-84
Requests for Hearing	142	142	103	205	140	66	6	5	192	295	583	713
Administrative Reviews	124	106	88	154	127	51	6	4	164	253	509	568
Fair Hearings	38	35	33	69	67	20	3	3	60	79	201	206

*Other includes general assistance, food stamps, economic assistance, and low income energy assistance.

Source: Office of the Legislative Auditor from SRS records

Illustration 21

When a person requests a fair hearing, his/her complaint is categorized by the hearings officer as either challenging a fact of the case or protesting an agency policy. The majority of requests for fair hearings were due to the claimant challenging a fact of the case. The following illustration breaks down the percent of fair hearing requests by category for the past five years.

PERCENT OF FAIR HEARING REQUESTS BY CATEGORY

Type of Request	Percent
Challenging a Fact	61%
Protesting a Policy	31%
Information Not Available	8%

Source: Office of the Legislative Auditor from SRS records

Illustration 22

HEARINGS FINDINGS

During our audit we sampled fair hearing cases which affected Medicaid eligibility to determine if: 1) county welfare offices were deemed correct in their original determinations concerning eligibility of the claimants and the amounts of benefits available to those persons; 2) hearings officers were consistent in their findings of cases that were similar in nature; and 3) findings were timely.

Correctness and Consistency

We found the hearings generally rule the counties were correct in their decisions. Appeals in favor of the claimant were ruled not to be the fault of county decisions. The contested case files usually contained insufficient information and the eligibility technicians denied the clients' assistance based on the limited facts available at that time. Eligibility could only be correctly determined after the information was researched and presented at a fair hearing. We also found the hearings officers to be consistent in their determinations and rulings.

Timeliness of Findings

According to the Code of Federal Regulations (CFRs) and the Administrative Rules of Montana (ARMs), the Medicaid agency must take final administrative action on a case within 90 days from the

date of request for a fair hearing. The federal government can reduce federal financial assistance to the state if there is failure to comply with its provisions.

As part of our audit we checked for agency compliance with the CFRs and ARMs. Three hundred twelve requests for fair hearings were received by SRS between April 9, 1984 and October 5, 1984. Seventy-nine of the findings were not completed in 90 days. We reviewed the cases to determine the reason for the delay. The following chart summarizes our findings.

REASONS FOR UNTIMELY DECISIONS

Administrative review not timely	18
Administrative review or fair hearing rescheduled	10
Hearings officer waiting for information from outside source	22
Client delayed process	14
A second hearing was needed	1
Hearing was timely but final disposition was not written in time limit	4
Review held; fair hearing not timely	2
Miscellaneous (a number of reasons for delay, county not aware of request, etc.)	8
Total	79

Source: Office of the Legislative Auditor from SRS records

Illustration 23

Twenty-three percent of the delays are a result of the administrative review process in the counties. Clients caused 18 percent of the delays by not signing or submitting needed forms sent by the county or state. Forty percent of the delays were caused by outside sources; either through claimants rescheduling hearings or the hearings officer waiting for information. SRS personnel caused approximately 8 percent of the delays.

SRS should stress to county directors and field supervisors the need to hold administrative reviews at the earliest possible time. If the process is delayed, the reasons should be documented so SRS has support for not meeting the 90-day time limit. Class

action lawsuits in other states indicate a need for documentation of the reasons for not completing hearings in a timely manner.

Documentation should be maintained in all the cases. If SRS were in a lawsuit concerning the timeliness of a finding, it would have difficulty supporting why cases are not completed in a timely manner. As stated previously, the federal government can reduce federal financial assistance to the state if there is failure to comply with time provisions or the state cannot prove it is in substantial compliance.

RECOMMENDATION #8

WE RECOMMEND THE DEPARTMENT:

A. STRESS THE NEED FOR TIMELY ADMINISTRATIVE REVIEWS IN THE COUNTIES; AND

B. DOCUMENT REASONS FOR NOT MEETING THE 90-DAY TIME LIMIT.

CHAPTER VII

MONTANA INCOME MAINTENANCE SYSTEM (MIMS)

The Montana Income Maintenance System (MIMS) contains information concerning economic assistance recipients. MIMS is an automated data processing system used to track client's eligibility and to generate warrants for Aid to Families with Dependent Children (AFDC) recipients and Medicaid identification cards. MIMS is administered by the Department of Social and Rehabilitation Services (SRS) personnel.

Because one of our objectives was to determine the effectiveness of current data processing methods in assisting with eligibility determination, we reviewed the use of MIMS generated reports in the counties and controls over the computer system at SRS. The remainder of this chapter explains the use of MIMS information, controls over the computer system, and our conclusions and recommendations in each area.

MIMS INFORMATION

During the initial determination process, eligibility technicians (ETs) complete turnaround documents (TADs) to be sent to SRS. These forms contain such information as applicant's name; address; Social Security number; type of aid requested; starting and ending dates of aid; any other members of the household and when they will be receiving aid; and which ET submitted the TAD.

TADs are sent to SRS and the information is key-entered onto diskettes. The diskettes are then taken to the Information Services Division, Department of Administration, and the information is transferred to MIMS. The information input into MIMS is printed by the computer onto new TADs. These TADs are then sent to the ET who submitted the information. When updates are made to the case, such as address changes or closure of eligibility, the ET fills out the appropriate boxes on the computer printed TAD and resubmits it to SRS.

Besides the new TADs, other information is also generated by MIMS. We reviewed the use of this information in the counties.

The following sections discuss this use and problems ETs have with MIMS output.

Matches

One type of output is "matches" with information on other computer systems. Matches are used during the redetermination process. They cannot be used during initial determination for new applicants since the person would not be listed on MIMS. Matches are performed monthly and/or quarterly, depending on the information sought. For example, the Social Security wage information from employers is only submitted quarterly to the state Department of Labor and Industry so the match is done quarterly.

Social Security numbers on MIMS are matched with Social Security numbers on other systems. Most of the matches are with information from Department of Labor and Industry records. Matches are completed between MIMS and the following records: 1) unemployment compensation payments; 2) workers' compensation payments; 3) Social Security wages report (submitted by employers listing those employees for whom Social Security benefits were paid); and 4) wages (income paid to employees). A match is also done with Veterans Administration benefits paid.

We reviewed records in the counties and talked to staff concerning the benefit of the "match" reports. Files we reviewed indicated the information is used. ETs told us the information is very useful and as a result of its use they have found people committing fraud; clients have been listed as matched with income on a report yet had not told the ET money was being received.

ETs had no complaints about the matching information they receive from SRS and consider it very useful. They thought some reports could be more timely. The reports they want more often are currently generated quarterly since the information is reported to the Department of Labor every three months. A monthly match of the quarterly information and MIMS would be useful to ETs. Although information is only updated quarterly on the Department of Labor and Industry system, new clients are added to MIMS daily. The new clients could be matched on a monthly basis to the

quarterly information and the results distributed to counties so ETs would have the information on new clients in a more timely manner.

RECOMMENDATION #9

WE RECOMMEND THE DEPARTMENT MATCH THE INFORMATION ON MIMS TO THE DEPARTMENT OF LABOR TAPES MONTHLY SO NEW CLIENTS WILL BE LISTED ON THE MATCHES.

MIMS Reports

Counties are also provided at least 27 other computer reports. These reports contain information recorded only on MIMS. While we were in the counties ETs complained about some of these reports. The ETs did not know how to use some of the reports; they did not know the purpose of others; and some reports the ETs never use. In August 1984 SRS obtained comments from ET supervisors concerning what changes to the reports the county staff would like. The following lists a summary of the comments pertaining to what was identified as the major problem with each report:

COMMENTS CONCERNING COMPUTER REPORTS

Comments	# of Reports
Wonder what the purpose of the report is	4
Combine with other printouts	2
Need hard copy	3
More timely	1
Delete	7
Need minor changes but want to keep	6
Okay as is	4
Total	27

Source: Office of the Legislative Auditor from SRS records

Illustration 24

We asked SRS personnel what had been done to modify or delete the printouts. As of November 1984, nothing had been done with the information SRS had gathered. If the printouts were modified or deleted, per the county staffs' requests, ETs' time could be made more efficient. Modification or deletion would also lower the level of frustration experienced by ETs over having to deal with some reports.

For example, one report the ETs are frustrated with is the "forms in suspense" report. This report is generated weekly and lists the TADs in each county which have errors on them. County staff are to circulate the report and indicate on the report: the status of the case; whether the TAD is correct; whether the case should be deleted from the list; if the error is corrected; or if he/she is working on correcting the problem. Most of the reports we reviewed requested the person to be deleted from the error report because the ET had submitted a correct TAD. ETs could not understand why, if they had submitted correct TADS, the clients still remained on the error report. In August SRS was asked by ET supervisors to: 1) provide instructions as to how to get names off the list; 2) act on comments on the error reports submitted from the county to SRS; and 3) include the client's name with all Social Security numbers. As of November none of the requested changes had been made.

If requested changes are made on the reports, they would then be useful to the ETs and possibly make their job easier.

RECOMMENDATION #10

WE RECOMMEND THE DEPARTMENT ASSESS THE USE AND NEED OF THE COMPUTER REPORTS SENT TO COUNTIES AND MODIFY OR DELETE THOSE NOT PRESENTLY UNDERSTOOD OR USED BY COUNTY STAFF.

Information in Other States

We also wanted to determine if information was available to ETs concerning whether a client was receiving aid in another state

while applying for, or receiving, aid in Montana. We found ETs must rely on information provided them by the client. If the client says he/she just came from another state, the ET will usually contact the other state to determine if the person is still receiving benefits. A computer match between MIMS and information in other states is not conducted to determine if a client is receiving benefits in another state. SRS personnel indicated the match could be available in a few years.

CONTROLS OVER INFORMATION

Access to Montana Income Maintenance System Information

During our review of controls over information on MIMS we noted a concern with access to computer programs and client information. As of July 2, 1984 SRS allowed 53 people in SRS read and execute access to the MIMS master file, backup files, and the programs that detail what programs and files are to be run and what forms, reports, warrants, etc., will be produced. In addition, SRS access controls allowed anyone in state government with a valid user identification number to read and execute the information.

SRS relies on compensating controls, such as passwords, other programs, and reviewing output, to protect the files and programs. Passwords, as presently used, should not be considered compensating controls since we were able to breach five out of eleven SRS passwords we tested.

Controls should limit access of MIMS information to the minimum number of individuals required to use the information for constructive business objectives. By allowing so many people access to the information there is a greater potential the system will be used for unauthorized purposes. Also, confidential information is available to people who do not need access to that information.

We suggested SRS personnel review their controls pertaining to MIMS information and limit the information to only those people

that require the information to conduct their business. They informed us they limited access to programs and information to 19 people.

Issuance of Medicaid Cards

MIMS generates Medicaid identification cards to be issued monthly to eligible recipients. Prior to cards being mailed, ETs are supposed to review a register that lists all clients that will receive cards in their county for that month. If someone is on the list and should not receive a card, a call is placed to SRS requesting the card not be sent.

In our visits in the counties we found the register is not always reviewed and "holds" placed on cards. We found instances where people were listed twice on the register and there was no indication one of the cards should not be sent to the recipients. In one case, the same person was listed with two Social Security numbers (one digit in the number was different) and sent two cards. In another case, the same person had a temporary case number (given to a client until a Social Security number is obtained) and a permanent number. A card was issued under both numbers. In reviewing microfiche listing people receiving Medicaid cards, we found five more people receiving two cards because they had two different numbers.

Each person is supposed to have one number and receive one card. Since there is no limit to the amount of services a person can receive with a Medicaid card, receiving two cards does not allow a person more benefits. Two cards to one person does make it difficult to trace information concerning utilization of services by a person. A periodic review of the Medicaid identification card register would ensure people are only receiving one Medicaid card. If people are found with two numbers on MIMS, the ET should submit a TAD to delete the incorrect number.

RECOMMENDATION #11

WE RECOMMEND ELIGIBILITY TECHNICIANS:

A. PERIODICALLY REVIEW THE MEDICAID IDENTIFICATION CARD REGISTER TO ENSURE PEOPLE ARE ONLY RECEIVING ONE CARD; AND

B. HAVE ANY INCORRECT NUMBERS DELETED SO PEOPLE DO NOT RECEIVE TWO CARDS UNDER TWO NUMBERS.

Third-Party Liability Information on TADs

When a client, or additional person on a TAD, has third-party liability, the information is to be included on the TAD. (A third party is an individual, institution, corporation, or public or private agency which may be liable to pay all or part of the medical cost of injury, disease, or disability of someone eligible for the Montana Medicaid program.) The ET must indicate the company, the policy number, type of coverage, and the dates of coverage. Each policy is then numbered consecutively (1, 2, 3). An identification code (1, 2, 3, or any combination of these) must also be entered in a separate area to designate the insurance policy(ies) listed which is(are) applicable to each person listed on the TAD.

We found ETs will include the company, policy number, type of coverage, and dates of coverage on the TAD, but the identification code is omitted. If there is no identification code listed, the computer system cannot identify any third-party liability with a particular person. When this happens, the insurance company will not be billed and Medicaid will pay for all services provided to the person.

This situation is currently not a problem since third-party liability information must be submitted in a letter to the fiscal agent that bills other insurance companies and the information on MIMS is not used. A problem may arise when a new fiscal agent assumes billing responsibilities in March 1985 since the agent must rely on information on MIMS. Before the responsibility switches SRS should do two things: 1) instruct ETs to fill out the insurance information correctly on the TAD; and 2) develop an edit in

the computer program to check whether a policy is listed, and if one is, an identification code is also indicated for at least one person on the TAD. These two items will help assure third parties are billed for services prior to Medicaid being billed.

RECOMMENDATION #12

WE RECOMMEND THE DEPARTMENT:

A. INSTRUCT ELIGIBILITY TECHNICIANS TO PROPERLY COMPLETE THIRD-PARTY LIABILITY INFORMATION; AND

B. DEVELOP AN EDIT IN MIMS TO ASSURE THIRD-PARTY LIABILITY INFORMATION IS PROPERLY RECORDED ON THE TAD.

CHAPTER VIII

COUNTY WELFARE OFFICE ORGANIZATION

While conducting our audit in the county welfare offices we noticed each office had different office procedures for accomplishing similar tasks in the eligibility process. Some methods appeared to be more efficient than others. The following sections discuss our concerns and recommendation.

INTAKE PROCESS

As noted in Chapter IV, the client must fill out an application for assistance. We found the method of distributing applications differs in the counties visited. For example, in one large county (with clerical help) the eligibility technicians (ETs) distribute the applications to the clients. They explain the types of assistance programs available to the clients and tell the clients what verifying information is needed. The ET sees the client again after he/she has completed the application. In other large and most medium sized counties visited, we found the clerical staff distributed applications and explained to the clients what initial verifying information is needed. In these counties ETs do not see the client until the application is completed as much as possible by the applicant. We also visited one medium size county where ETs distribute the applications and help the client fill out the application. They do this because they believe clients continually ask the clerical staff questions the clerical staff cannot answer.

We also found the process of seeing clients differs. In the majority of the counties we visited clients made appointments to see an ET at the time the client received the application. In other counties, ETs saw clients on a "first-come, first-serve" basis. If all the ETs were busy all day, the client had to return the next day.

The third process that differed between counties concerns the type of cases the ETs handle. Some counties had specific ETs process applications while the remaining ETs handled the cases after initial eligibility was determined. Three large counties had

all the ETs taking new applicants plus handling a continuing caseload. Three medium size counties also had all the ETs processing intakes. Only one large and one medium size county visited had specific people handle intake cases, while the remaining ETs handled continuing eligibility.

Most of the counties also had specified time periods when ETs would interview applicants. For example, one county only did intakes in the afternoon. Another county had AFDC and Medicaid intake three and one-half days a week. A third county normally scheduled four days a week for intake and one full day for paperwork. Occasionally, this county scheduled intakes only one day and reserved the remaining days for paperwork. Applications can be obtained at any time so counties are in compliance with the rule stating people can apply for aid any time during the week.

Procedures during the intake process differ between counties. We observed counties performing one type of procedure efficiently, yet other procedures appear inefficient. If county offices were to use more efficient procedures, ETs would have more available time. For example, having clerical staff, in counties with this staff, distribute applications and explain to clients what initial verifying information is needed would save time. Also, making appointments to see a specific client would help ETs organize their time. Splitting the intake and continuing eligibility functions, in counties where this is possible, could also increase efficiency by allowing ETs to concentrate in one area.

FORM LETTERS

We found ETs must communicate, through a letter, to their clients quite frequently. For example, if an AFDC client does not send in the monthly reporting form by the eighth of the month, a letter must be sent stating the case will close if the information is not received by the eighteenth. We found instances where letters were sent every month informing clients of changes. Some counties type a new letter each time the client needs to be informed. Other counties have a form letter preprinted and the ET only has to mark the appropriate box. Using form letters provides more

assurance the letters will be sent in a timely manner, and also reduces secretarial (and in some counties ET) time typing repetitive letters. State-assumed counties have been provided word processors which will reduce time spent typing letters.

Use of form letters would reduce both secretarial and ET time in typing repetitive letters. If SRS consolidates AFDC, Medicaid, and other forms, it could also review types of letters sent.

SUMMARY

SRS should help counties become more efficient, thus creating more available time for ETs. State statutes direct the department to ". . . provide services in respect to organization and supervise county Departments of Public Welfare and county Boards of Public Welfare in the administration of public assistance functions and for efficiency and economy." (53-2-201, 1(e), MCA). The department should follow the directives of this statute and help the counties create more efficient procedures concerning public assistance programs. Providing word processors to state-assumed counties should make those counties more efficient. As far as we have determined, SRS has not given counties any direction concerning internal operations or efficiency of individual county offices.

SRS is requesting 54 additional FTE for the biennium, according to the 1985 Executive Budget, to be distributed among counties with increased workload. The largest portion of the FTE are to be varied classifications of eligibility technicians. Adding more ETs may provide for more time per ET to determine eligibility and conduct redeterminations but will not address the inefficiencies of current practices in each county. We suggest SRS help each county establish practices that will allow the assistance programs in the counties to operate more efficiently.

RECOMMENDATION #13

WE RECOMMEND THE DEPARTMENT HELP COUNTIES ESTABLISH PRACTICES THAT WILL ALLOW ASSISTANCE PROGRAMS IN THE COUNTIES TO OPERATE MORE EFFICIENTLY.

AGENCY RESPONSE

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 4

STATE OF MONTANA

HELENA, MONTANA 596

February 8, 1985

Scott A. Seacat
Deputy Legislative Auditor
Office of the Legislative Auditor
State Capitol
Helena, MT 59620

Dear Scott,

Attached is the Department of Social and Rehabilitation Services' response to your performance audit of the Medicaid Eligibility Determination process. I would like to take this opportunity to thank you and your staff for a very thorough and well-written report.

As you can see from our responses, we concur with all of your recommendations and will, in the very near future, take steps to implement each of these recommendations.

If further information or discussion is required, please contact me directly.

Sincerely,

Dave Lewis
Director

JDE/059a

Attachment

RECOMMENDATION #1: We recommend SRS take a more active role in managing the eligibility determination program.

AGENCY RESPONSE: Concur. The Department is implementing many changes as explained in our responses to the other recommendations. In addition to these, the Regional Field Supervisors are conducting studies of procedures and office operations specific to programs. Processes for GA and State Medical is the first study which is to be completed by February 28, 1985. The data from the studies will be evaluated by Field Services Bureau and then followed up with recommendations for changes in the county offices.

The Field Services Bureau will be refining the current performance appraisal system for eligibility staff to place more emphasis on accurate performance of the county workers and allow for a more active role for Field Supervisors in the appraisal process.

RECOMMENDATION #2: We recommend the Department continue its efforts to increase the information available to eligibility technicians to verify information provided by clients.

AGENCY RESPONSE: Concur. The Department is revising the current policy manual to include a new section that will detail the application and redetermination process. This section will mandate the eligibility technician to obtain and circulate a Release of Information form for all Medicaid Assistance clients. Field Supervisors will also spot check cases for investigation of resource.

Pending legislation will allow the Department to access specific client information obtained by Department of Revenue.

RECOMMENDATION #3: We recommend the Department redesign and consolidate the forms used by eligibility technicians.

AGENCY RESPONSE: Concur. Forms consolidation is a Department priority. An ad hoc committee will be appointed by April 1, 1985. Their task will be to consolidate duplicative forms, eliminate unnecessary forms, redesign unwieldly forms and reduce the number of forms required for eligibility.

RECOMMENDATION #4: We recommend the Department:

A. Explain the need of the eligibility intake checklist form to the eligibility technicians; and

B. Review a sample of cases to ensure eligibility technicians are obtaining the client's signature on the form.

AGENCY RESPONSE: Concur. During monthly county visits in March and April of 1985, the Field Supervisors will be discussing use of and suggested revisions to the eligibility intake checklist form. The form will then be revised and instructions on use of form will be provided to counties.

In December 1984 and January 1985 at Regional Corrective Action meetings and county visits, the Field Supervisors informed workers that both the client and eligibility technician must sign the application form. A random sample of cases to check for signatures will be conducted by Field Supervisors in all counties by April 30, 1985.

RECOMMENDATION #5: We recommend the Department use available information to:

A. Identify problems ETs could be having in completing forms; and

B. Monitor the eligible population.

AGENCY RESPONSE: Concur.

A. The system generates a Worker Error Report which identifies, by county and worker, the type of error made and the frequency with which it occurs. The report also ranks this data in these same categories. Management Operations Bureau has been using this data to identify coding problems and we have been discussing these on an individual basis with the appropriate staff.

We recognize that this Error List has the potential of functioning as a management tool and have made that recommendation to the Field Services Bureau. They have indicated they will implement use of the list with the Field Supervisors in the near future.

B. The demographic information available in MIMS has been utilized by our staff to determine distribution of households and project caseloads and changes in client population. However, during the time the audit was performed, we had staff changes and the responsibility of monitoring this data was reassigned. The person responsible for analyzing this demographic data has now become very familiar with the system and regularly extracts this information.

RECOMMENDATION #6: We recommend the Department take steps to assure:

A. Everyone is receiving policies; and

B. Policies are being placed in the manuals.

AGENCY RESPONSE: Concur. The Department will issue new policies on a quarterly basis. Counties are being asked to distribute, discuss, and insert in the manual all new policies at a staff meeting. The present system of quarterly notification of receipt of policy will continue with followup by Field Supervisors.

RECOMMENDATION #7: We recommend the Department review its policy concerning updating bulletins to determine whether the current policy is needed.

AGENCY RESPONSE: Concur. The Department will issue policy bulletins only when absolutely necessary. All bulletins will be tracked by displaywriter and incorporated into the manual quarterly. A memo outlining the bulletin procedure will be sent to the counties by February 28. Present bulletins will be incorporated into the manual by March 31, 1985.

RECOMMENDATION #8: We recommend the Department:

A. Stress the need for timely administrative reviews in the counties; and

B. Document reasons for not meeting 90-day time limit.

AGENCY RESPONSE: Concur. We currently have in place on our word processors, a system to followup on administrative reviews if not completed in a timely manner. This system will be further refined by requiring counties to indicate on the Administrative Review Report, Form SRS-LS-007, in Reviewer narrative block, why the Administrative Review was not completed in the 15-day limit.

The Department is currently in the process of hiring an additional hearings officer which should alleviate the backlog of hearings.

RECOMMENDATION #9: We recommend the Department match the information on MIMS to the Department of Labor tapes monthly so new clients will be listed on the matches.

AGENCY RESPONSE: Concur. This recommendation has already been implemented and is in the process of being written by our Data Processing Bureau. The project should be completed in 30 days. At that time, counties will begin receiving a match printout for new cases on a monthly basis.

RECOMMENDATION #10: We recommend the Department assess the use and need of the computer reports sent to counties and modify or delete those not presently understood or used by county staff.

AGENCY RESPONSE: Concur. All computer printouts were evaluated by a group of county and state workers. Recommendations for changes to and deletions of the current computer printouts will be given a final evaluation by Management Operations Bureau and field service staff in light of federal requirements, need for statistical data, etc., and then the recommendation will be acted upon. This should be completed by June 30, 1985.

RECOMMENDATION #11: We recommend eligibility technicians:

A. Periodically review the Medicaid identification card register to ensure people are only receiving one card; and

B. Have any incorrect numbers deleted so people do not receive two cards under two numbers.

AGENCY RESPONSE: Concur. The State will prepare a letter to the counties which instructs them to review the Medicaid Identification card register every month. They will also be instructed to delete any incorrect numbers by closing the case via a TAD so that clients cannot receive two cards.

RECOMMENDATION #12: We recommend the Department:

A. Instruct eligibility technicians to properly complete third-party liability information; and

B. Develop an edit in MIMS to assure third-party liability information is properly recorded on the TAD.

AGENCY RESPONSE: Concur.

A. A letter and a printout was sent to the counties this past month instructing them how to properly complete Third-Party Liability Information on the TAD.

B. It is not possible to create an edit in MIMS to assure that the Third-Party information is properly recorded on the TAD since some clients will have insurance and others would not. The system has to allow the technician to indicate which is applicable and the state must rely on the technician to input the correct information.

RECOMMENDATION #13: We recommend the Department help counties establish practices that will allow assistance programs in the counties to operate more efficiently.

AGENCY RESPONSE: Concur. The word processing equipment, which has been installed in 18 counties, will aid counties in using the same letters, reporting, check writing systems, etc.

The Field Supervisors' studies of county operations, as explained in our response to Recommendation #1, will hopefully alleviate inefficient operations in counties and be a positive move to more consistent and efficient county operations.